DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/27/2012 FORM APPROVED MR NO DOSS_DSS1

IDENTIFICATION NUMBER: 445047 A BUILDING B WING C 08/15/2012 STREET ADDRESS, CITY, STATE. 2IP CODE 306 W DILE WEST AVE MADISON, TN 37115 STREET ADDRESS, CITY, STATE. 2IP CODE 306 W DILE WEST AVE MADISON, TN 37116 PROPRESS LEACH DEPICIENCY MUST BE PRICEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) F 281 483.20(k)(3)(f) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quelity. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to follow Physician's orders for intravenous medication administration for one resident (#2) of five residents reviewed. The findings included: Resident #2 was admitted to the facility on August 17, 2010, and readmitted to the facility on August 17, 2010, and readmitted to the facility on August 17, 2010, and readmitted to the facility on August 17, 2010, and readmitted by Saccular Dementia, Peripheral Vascular Disease, CVA (stroke), Diabeles, and Hyperipidemia. Medical record review of the Annual Minimum Data Set (MDS), dated July 30, 2012, revealed the resident was severely cognitively impaired and dependent for all activities of daily living. Observation on August 13, 2012, at 1:30 p.m., in the resident's revoke of the resident's revisition, a bed wedge cushion in place, and a Wound Vac (negative pressure pump used to remove drainage from large or complicated wounds) and a dressing in place on the residents sacral area (railbone). Continued observation revealed an I.V. (intravenous medication) pole beside the bed, and an empty 100 mil (milliter) vnnyl bag of intravenous medication labeled, 71 Tedaro (an antibiotic) 600 mg/100 ml (six hundred milligrams			C INCOTO CLITTICE				ON DIVID	. 0930-039
NAME OF PROVIDER OR SUPPLIER IMPERIAL GARDENS HEALTH AND REHABILITATION IMADISON, TN 37116 SUMMARY STATEMENT OF DEFICIENCES PREET TAG SUMMARY STATEMENT OF DEFICIENCES TAG PROFESSION OF CORRECTION (CARCICORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG This Plan of Correction (POC) has been developed in compliance with State and Federal Regulations. This Plan affirms Imperial Gardens the Health and Rehabilitation's intent and allegation of compliance with those regulations. This POC does not constitute an admission or concession of either accuracy or factual allegation made in, or existence or scope of significance, of any cited deficiency. The findings included: Resident #2 was admitted to the facility on July 17, 2010, and readmitted to the facility on July 17, 2010, and readmitted to the facility on July 17, 2010, and readmitted to the facility on July 17, 2010, and readmitted to the facility on July 17, 2010, and readmitted to the facility on July 17, 2010, and readmitted to the facility on July 17, 2010, and readmitted to the facility on July 17, 2010, and readmitted to the facility on July 17, 2010, and readmitted to the facility on July 17, 2010, and readmitted to the facility on July 1	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			, ,		ONSTRUCTION		
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IMPERIAL GARDENS HEALTH AND REHABILITATION			445047	B. WIN			08/	
FREINT TAG REGULATORY OR USC IDENTIFYING INFORMATION) F 281 483.20(k)(3)(ii) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to follow Physician's orders for intravenous medication administration for one resident (#2) of five residents reviewed. The findings included: Resident #2 was admitted to the facility on July 17, 2010, and readmitted to the facility on August 7, 2012, with diagnoses including Hypertension, Vascular Dementia, Peripheral Vascular Disease, CVA (stroke), Diabetes, and Hyperlipidemia. Medical record review of the Annual Minimum Data Set (MDS), dated July 30, 2012, revealed the resident was severely cognitively impaired and dependent for all activities of daily living. Observation on August 13, 2012, at 1:30 p.m., in the resident's room revealed the resident in bed, lying in the right oblique position, a bed wedge cushion in place, and a Wound Vac (negative pressure pump used to remove drange from large or complicated wounds) and a dressing in place on the resident sacral area (talibone). Continued observation revealed an I.V. (intravenous medication) pole beside the bed, and an empty 100 ml (milliliter) vinyl bag of intravenous medication labeled, 'Teflaro (an antibiotic) 600 mg/100 ml (six hundred milligrams			AND REHABILITATION	_	306 W	DUE WEST AVE		
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ABORATORY DIRECTORS OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		Resident #2 was ac 17, 2010, and read 7, 2012, with diagnous Vascular Dementia CVA (stroke), Diabe Medical record revidence Set (MDS), dathe resident was seand dependent for a Observation on Augthe resident's room lying in the right oblicushion in place, ar pressure pump use large or complicate place on the resider Continued observat (intravenous medical and an empty 100 rintravenous medical residence on the resider continued observation and an empty 100 rintravenous medical residence on the resider continued observation and an empty 100 rintravenous medical residence on the resider continued observation and an empty 100 rintravenous medical residence on the resider continued observation and an empty 100 rintravenous medical residence of the re	2 was admitted to the facility on July and readmitted to the facility on August th diagnoses including Hypertension, bementia, Peripheral Vascular Disease, i.e.), Diabetes, and Hyperlipidemia. Cord review of the Annual Minimum MDS), dated July 30, 2012, revealed at was severely cognitively impaired dent for all activities of daily living. In on August 13, 2012, at 1:30 p.m., in at's room revealed the resident in bed, right oblique position, a bed wedge place, and a Wound Vac (negative ump used to remove drainage from in the residents sacral area (tailbone), observation revealed an I.V. is medication) pole beside the bed, pty 100 ml (milliliter) vinyl bag of s medication labeled," Teflaro (an			assessed by the Director of Nursing adverse outcomes we The Assistant Director on 8/13/12 no attending physiciar pharmacist with no ne received. A 100% audit of resintravenous antibiotic completed by Unit Manno other residents were be affected. In serv proper intravenous administration by the Educator and Assistant of Nursing on 8/13/13	Assistant and no re noted. ector of tified the n and ew orders dents on cs was lager and e found to icing for antibiotic e Nurse t Director 2 with	
A LE TENTE TO THE CONTRACT OF	BORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	VATURE	. 1	TITLE		(X6) DATE

R PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

9-6-2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: TN1912

PRINTED: 08/27/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 445047 08/15/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 306 W DUE WEST AVE IMPERIAL GARDENS HEALTH AND REHABILITATION MADISON, TN 37115 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) All licensed nurses are being in F 281 Continued From page 1 F 281 serviced by Nurse Educator on in one hundred milliliters) NS (normal satine) over intravenous antibiotic proper 60 min (over sixty minutes) bid (twice daily) administration starting 8/17/12 hanging from the pole. Continued observation All licensed nursing 9/7/2012. revealed the medication vial affixed to the bottom personnel hired after 9/7/2012 of the bag contained approximately 3 milliliters of will receive training as part of medication that had not been mixed into the I.V. their orientation from the Nurse bag after it was reconstituted (Mixed with saline Educator. prior to being added to the intravenous solution). Interview with the staff member present in the 4. Director of Nursing and or room revealed the I.V. medication was given in Clinical Unit Managers will audit the morning and at night, and the infusion had all residents on intravenous been completed earlier that day. antibiotics for appropriate administration 4 times week for 2 Review of the manufacturer's specifications for weeks; then 3 times week for 4 Teflaro revealed "...dosage weeks; then monthly for 2 strength...600...volume of diluent to be added, ML months and/or until 100% (Milliliters) 20...Approximate Concentration... compliance is achieved. (mg/m) {milligrams per milliliter}...30...amount to results will be reported by the be withdrawn...total volume..." Nurse Educator to the Quality Assurance Performance Interview with the Quality Improvement Improvement Committee which Coordinator on August 13, 2012, at 1:55 p.m., in is comprised of the Medical the resident's room confirmed the Intravenous Director, Administrator, Director medication had been improperly administered. Clinical Nursing, Unit Managers, Nurse Educator, MDS

FORM CMS-2567(02-99) Previous Versions Obsolete

of disease and infection.

Program under which it -

(a) Infection Control Program

C/O #30259

SS=D SPREAD, LINENS

F 441 483.65 INFECTION CONTROL, PREVENT

The facility must establish and maintain an

Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission

The facility must establish an Infection Control

Event ID: 30ZY11

Facility ID: TN1912

F 441

If continuation sheet Page 2 of 4

Manager.

Services

Plant

and

9-14-12

Coordinator, Dietary

Activities

Manager.

Operations

Environmental

Director,

Manager,

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/27/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1				(X3) DATE SURVEY COMPLETED	
		445047	A. BUILE			_		C 5/2012
	SUMMARY ST (EACH DEFICIENC	TH AND REHABILITATION TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	306 W DUE	RESS, CITY, STATE, ZIF E WEST AVE I, TN 37115 PROVIDER'S PLAN OF ACH CORRECTIVE AC' SS-REFERENCED TO' DEFICIENCE	CORRECTION SHOW	TION ULD BE	(X5) COMPLETION DATÉ
	Continued From page 2 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.		F 44	a punto a secondaria s			ed in a /2012 by d was loor. On rector of attending v orders manager with no Foley ge bag charge 13/12 by d central residents completed ent was	
	transport linens so infection. This REQUIREMS by: Based on observe failed to maintain	andle, store, process and of as to prevent the spread of ENT is not met as evidenced ation and interview, the facility infection control measures for of five residents reviewed.		n s p p 9	All Licensed sursing state of the state of t	aff will se educ ag and arting ed and 9/7/12	tubing 8/17/12- certified will be	
	The findings included:							
		admitted to the facility on July dmitted to the facility, on August						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING B. WING			c	
		445047	S. 11110_			08/15	5/2012
NAME OF PROVIDER OR SUPPLIER IMPERIAL GARDENS HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 306 W DUE WEST AVE MADISON, TN 37115				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULO BE	(X5) COMPLETION DATE
F 441	Vascular Dementia CVA (stroke), Diab Medical record revident Set dated July resident was sever dependent for all a Observation on Author resident's room indwelling urinary of drainage bag. The contained seven his colored urine, with the clear tubing an catheter bag was at the bed was in the observation revealed drain line (used to contact with the Coordinator, on Author resident's room	oses including Hypertension, a Peripheral Vascular Disease, etes, and Hyperlipidemia. iew of the Annual Minimum y 30, 2012, revealed the ely cognitively impaired and ctivities of daily living. gust 13, 2012, at 1:30 p.m., in a revealed resident #2 with an eatheter attached to a beside bedside drainage bag undred milliliters of dark, tea heavy white sediment noted in d the drainage bag. The attached to the bed frame and low position. Continued ed the urinary catheter bag empty the bag) was in direct	F 441	4.	improvement Committee is comprised of the Director, Administrator, I of Nursing, Clinical Managers, Nurse Educate Coordinator, Dietary Mactivities Director, Operations Manager,	I Unit ducator tubing for 2 k for 4 for 2 100% The by the Quality rmance which Medical Director Unit or, MDS	9-14-12